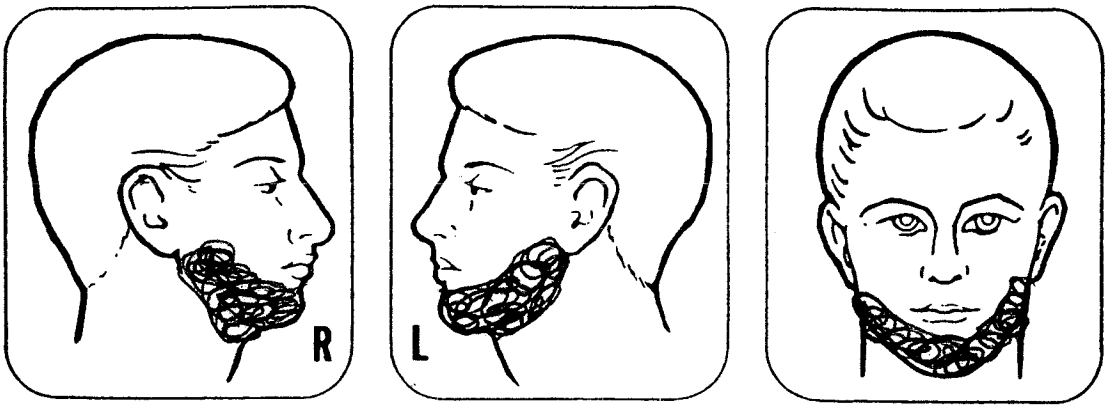
DEPARTMENT OF CORRECTIONS
SHAVE PROFILE AUTHORIZATION

DATE: 6/18/04 ORIGINATING INSTITUTION/WORK RELEASE CENTER Ventress

REASON FOR PROFILE facial rash

TREATMENT: shave to 1/8" in shaded area x 6mo

SHAVE PROFILE INSTRUCTIONS



1. Specific area of face or neck involved is to be identified on the above profiles by the physician.
2. Hair in the areas shown on the diagrams is not to exceed 1/8".
3. The type shave to be used is clipper.
4. This shaving profile expires on 12/18/04.
5. Any corrections automatically cancel this profile authorization.
6. If the shaving profile is to be extended beyond the date indicated, a new Shave Profile Authorization must be completed and distributed appropriately.
7. Designated copies of this Shaving Profile Authorization have been distributed to:

☐ Warden ___/___/___
DATE

☒ Inmate 6/18/04
DATE

Sidney Clayton Bey

M Benfield Lpn
NURSE'S SIGNATURE
(Distributed By)

Rayapati
PHYSICIAN'S SIGNATURE
(Authorization)

FULL NAME (Last, First, Middle)	Date-of-Birth	Age	R/S	AIS #
Clayton, Sidney	3-23-76		B/M	224797

ORIGINAL - Blue Medical Jacket
YELLOW - Inmate
PINK - Warden

F-13

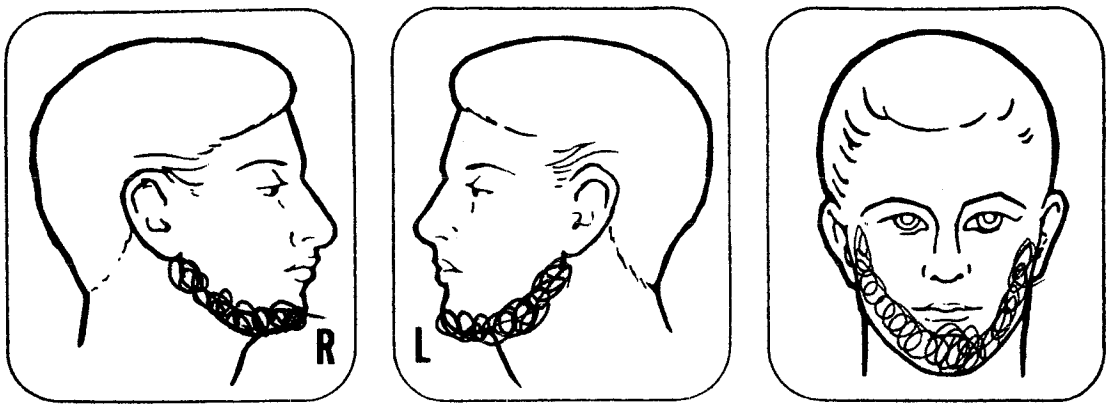
DEPARTMENT OF CORRECTIONS
SHAVE PROFILE AUTHORIZATION

DATE: 12/16/03 ORIGINATING INSTITUTION/WORK RELEASE CENTER Ventress

REASON FOR PROFILE facial folliculitis

TREATMENT: clipper shave follow instructions below

SHAVE PROFILE INSTRUCTIONS



1. Specific area of face or neck involved is to be identified on the above profiles by the physician.
2. Hair in the areas shown on the diagrams is not to exceed 1/8".
3. The type shave to be used is clipper.
4. This shaving profile expires on 6/16/04.
5. Any corrections automatically cancel this profile authorization.
6. If the shaving profile is to be extended beyond the date indicated, a new Shave Profile Authorization must be completed and distributed appropriately.
7. Designated copies of this Shaving Profile Authorization have been distributed to:

☐ Warden ____/____/____ DATE

☒ Inmate 12/16/03 DATE

[signature] Ms Cooley CRNP

NURSE'S SIGNATURE (Distributed By) — PHYSICIAN'S SIGNATURE (Authorization)

FULL NAME (Last, First, Middle)	Date-of-Birth	Age	R/S	AIS #
Clayton, Sidney	3-23-76	27	B/m	224797

ORIGINAL - Blue Medical Jacket
YELLOW - Inmate Sidney Clayton
PINK - Warden

F-13

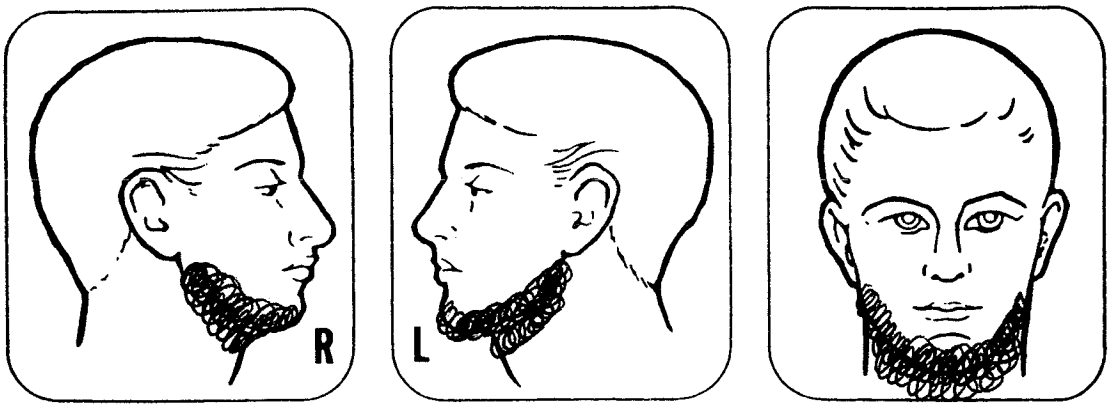
DEPARTMENT OF CORRECTIONS
SHAVE PROFILE AUTHORIZATION

DATE: 06/18/03 ORIGINATING INSTITUTION/WORK RELEASE CENTER Ventress Correctional

REASON FOR PROFILE Facial irritation

TREATMENT: Clipper shave shaded area 1/8th inch from skin X six months 6/18/03 – 12/18/03

SHAVE PROFILE INSTRUCTIONS



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2. Hair in the areas shown on the diagrams is not to exceed 1/8".
3. The type shave to be used is clipper.
4. This shaving profile expires on 12/18/03.
5. Any corrections automatically cancel this profile authorization.
6. If the shaving profile is to be extended beyond the date indicated, a new Shave Profile Authorization must be completed and distributed appropriately.
7. Designated copies of this Shaving Profile Authorization have been distributed to:

☐ Warden ____/____/____ DATE

☒ Inmate 06/18/03 DATE

P Johnson LPN
NURSE'S SIGNATURE
(Distributed By)

M Cooley CRNP / P Johnson LPN
PHYSICIAN'S SIGNATURE
(Authorization)

FULL NAME (Last, First, Middle)	Date-of-Birth	Age	R/S	AIS #
Clayton, Sidney	3-23-76		B/M	224797

ORIGINAL - Blue Medical Jacket
YELLOW - Inmate
PINK - Warden

Sidney Clayton

F-13

HEALTH CARE UNIT
PATIENT INFORMATION SLIP

VCF
INSTITUTION

Clayton, Sidney NAME 224797 NUMBER B/m R/S

Lay-in for ______ days from ______ (date) to ______ (date) due to ______

Report to HCU M Tues
June 17th 2003 at 8:15AM

Instructions: for appt with Mr
Conf for Shav Profile

Failure to follow the directions above may result in a disciplinary.

6/15/03
Date Issued

[signature]
Signature

Sidney Clayton

NAPHCARE

RELEASE OF RESPONSIBILITY

Clayton Sidney — 6/1/03
Name of Inmate — Date

224791 3-23-70
Inmate ID Number / Date of Birth

I hereby refuse to accept the following treatment/recommendations:

No show to sick call. on 6/1/03

I acknowledge that I have been fully informed of and understand the above treatments or recommendations and the risk(s) involved in refusing. I hereby release and agree to hold harmless NAPHCARE, its employees and agents from all responsibility and ill effect which may result from this action.

Inmate Signature — Date/Time

Witness

The aforementioned inmate has refused the listed medical treatment/recommendations and has refused to sign this form.

D. Teal RN
Witness

Witness

Date/Time

HEALTH CARE UNIT
PATIENT INFORMATION SLIP

VCF

INSTITUTION

Clayton Sidney NAME 22479 NUMBER B/M R/S

Lay-in for _____ days from _____ (date) to _____ (date)

due to _____

Instructions: Return to HCU on 5-14-03 at 900 am for EKG

Failure to follow the directions above may result in a disciplinary.

5-12-03 Date Issued

Signature

Sidney Clayton

F-53

HEALTH CARE UNIT
PATIENT INFORMATION SLIP

VCF

INSTITUTION

Clayton Sidney NAME 22479 NUMBER B/M R/S

Lay-in for _____ days from _____ (date) to _____ (date)

due to _____

Instructions: Return to HCU on 5-12-03 at 1:30 pm for MD appt w/ Dr Daboye

Failure to follow the directions above may result in a disciplinary.

5-7-03 Date Issued

Signature

Sidney Clayton

F-53

HEALTH CARE UNIT
PATIENT INFORMATION SLIP

VCF

INSTITUTION

Clayton Sidney 224797 B/R

NAME NUMBER R/S

Lay-in for _____ days from _____ to _____

(date) (date)

due to _____

(date)

Instructions: Return to HCU at 5Am & 6:30pm

5-8-03 5-9-03 5-10-03

5 Am 5 Am 5 Am

6:30 pm 6:30 pm 6:30 pm

Failure to follow the directions above may result in a disciplinary.

5-7-03 _____

Date Issued Signature

Sidney Clayton

HEALTH CARE UNIT
PATIENT INFORMATION SLIP

VCF

INSTITUTION

Clayton, Sidney 224797 B/R

NAME NUMBER R/S

Lay-in for _____ days from _____ to

(date) (date)

due to _____

(date)

Instructions: Benzoyl Peroxide 5% lotion twice a day for fourteen days KOP 12/17/02 - 12/31/02

Failure to follow the directions above may result in a disciplinary.

12/17/02 _____

Date Issued Signature

Sidney Clayton

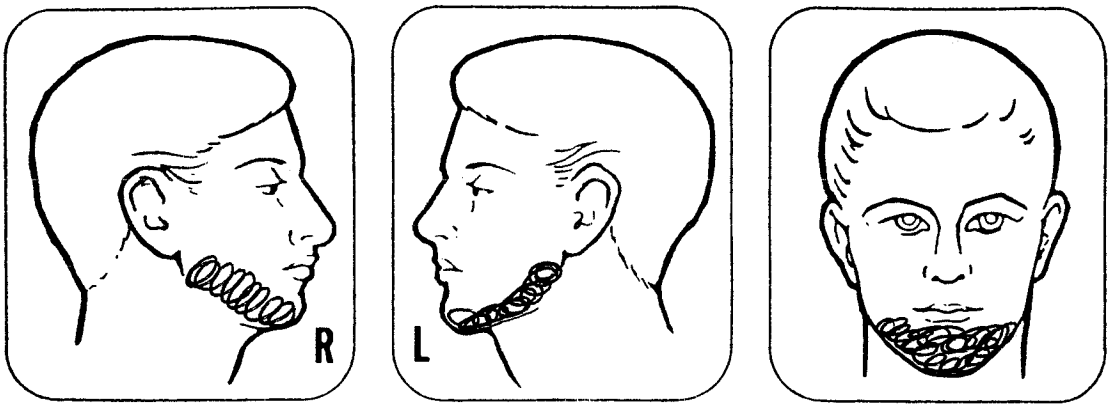
DEPARTMENT OF CORRECTIONS
SHAVE PROFILE AUTHORIZATION

DATE: 12/17/02 ORIGINATING INSTITUTION/WORK RELEASE CENTER VCF

REASON FOR PROFILE skin irritation

TREATMENT: shaving profile for six months no sideburns / no mustache

SHAVE PROFILE INSTRUCTIONS



1. Specific area of face or neck involved is to be identified on the above profiles by the physician.
2. Hair in the areas shown on the diagrams is not to exceed 1/8".
3. The type shave to be used is clipper.
4. This shaving profile expires on 6/17/03.
5. Any corrections automatically cancel this profile authorization.
6. If the shaving profile is to be extended beyond the date indicated, a new Shave Profile Authorization must be completed and distributed appropriately.
7. Designated copies of this Shaving Profile Authorization have been distributed to:

☐ Warden ____/____/____ DATE

☒ Inmate 12/17/02 DATE

N Strickland RSPN
NURSE'S SIGNATURE
(Distributed By)

PHYSICIAN'S SIGNATURE
(Authorization)

FULL NAME (Last, First, Middle)	Date-of-Birth	Age	R/S	AIS #
Clayton, Sidney	3-23-76	26	B/M	224797

ORIGINAL - Blue Medical Jacket
YELLOW - Inmate

PINK - Warden

Sidney Clayton

F-13

HEALTH CARE UNIT
PATIENT INFORMATION SLIP

UCF

INSTITUTION

Clayton, Sidney 224797 B/M

NAME NUMBER R/S

Lay-in for ~~days from~~ _____ to _____

(date)

_____ due to _____

(date)

Instructions: Return to HCU on Tuesday 12/12/02 at 8:30 AM to see Ms King CRNP —

Failure to follow the directions above may result in a disciplinary.

12/4/02 _____

Date Issued Signature

VERIFICATION OF ACCESS TO HEALTH CARE

This is to certify that I have received verbal and written access to health care instructions, to include oral hygiene instructions. I have had the opportunity to ask questions and to have my questions answered.

Sidney Clayton
SIGNATURE

224797
AIS NUMBER

[illegible]
WITNESS

12/1/02
DATE

Ventress Correctional Facility

NAPHCARE

INMATE FOOD SERVICE WORKER CLEARANCE

MEDICAL RECORD REVIEW:

Past history of hepatitis:	__ Yes	✓ No
TB test current:	✓ Yes	__ No
TB test negative:	✓ Yes	__ No

If history of positive TB test, verified completed treatment: _____ (Date)

PHYSICAL ASSESSMENT:

Open sores or rashes on hands, arms, face and neck: R/T shaving	✓ Yes	__ No
Has diarrhea:	__ Yes	✓ No
Has a cough:	__ Yes	✓ No
Lungs clear to auscultation:	✓ Yes	__ No
Signs and symptoms of other contagious diseases:	__ Yes	✓ No

Specify: _____

This inmate's Medical Record has been reviewed and he/she has been examined:

✓ He/she **IS** medically cleared for duty as a food service worker.
__ He/she **IS NOT** medically cleared for duty as a food service worker.

W Buchanan RN — 12/14/02
Signature — Date

NAME:	ID#/DOB:	LOCATION:
Clayton Sidney	224092 / 3-23-74	JCF

NAPHCARE

FOOD SERVICE WORKER GUIDELINES

CAPS

1. Put cap on before washing hands.
2. Be sure to include all hair, especially bangs on the front of the head.
3. Do not touch hair or cap when handling food.

HANDWASHING

1. Turn warm water on.
2. Wet hands.
3. Lather hands with soap. Scrub at least 30 seconds.
4. Rinse off bar of soap. Replace in soap dish.
5. Rinse hands.
6. Dry hands with paper towels.
7. Turn faucet off with paper towels.

SICKNESS

Tell kitchen officer if you feel ill, or if you have diarrhea or a rash.

I have received education on hand washing and personal hygiene, and I understand the need for both, especially when handling food on kitchen detail.

Sidney Clayton
INMATE SIGNATURE

12/11/02
DATE

[signature]
NURSE'S SIGNATURE

12/11/02
DATE

HEALTH CARE UNIT
PATIENT INFORMATION SLIP

KCF

INSTITUTION

Clayton, Andrew D. 224747 B/M

NAME NUMBER R/S

Lay-in for _____ days from _____ to

(date)

_____ due to _____

(date)

Instructions: Shave profile

Clozaril only X

90 days

Failure to follow the directions above may result in a disciplinary.

12/6/02

Date Issued

Signature

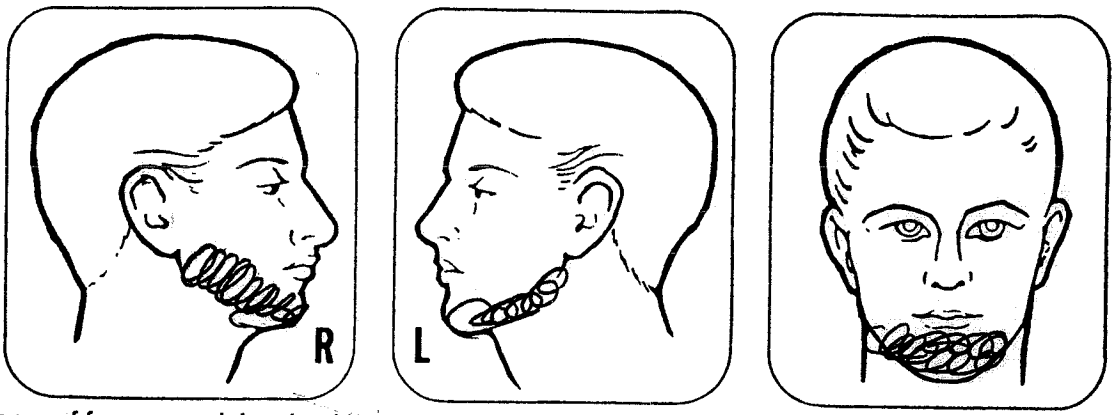
DEPARTMENT OF CORRECTIONS
SHAVE PROFILE AUTHORIZATION

DATE: 12/11/02 ORIGINATING INSTITUTION/WORK RELEASE CENTER VCF

REASON FOR PROFILE Skin irritation

TREATMENT: Shaving Profile ~~1/8~~ 90 days
NO sideburns / no mustache

SHAVE PROFILE INSTRUCTIONS



1. Specific area of face or neck involved is to be identified on the above profiles by the physician.
2. Hair in the areas shown on the diagrams is not to exceed 1/8".
3. The type shave to be used is clipper.
4. This shaving profile expires on 3/6/03.
5. Any corrections automatically cancel this profile authorization.
6. If the shaving profile is to be extended beyond the date indicated, a new Shave Profile Authorization must be completed and distributed appropriately.
7. Designated copies of this Shaving Profile Authorization have been distributed to:

☐ Warden ____/____/____ DATE

☒ Inmate 12/11/02 DATE

S Strickland for R
NURSE'S SIGNATURE
(Distributed By)

PHYSICIAN'S SIGNATURE
(Authorization)

FULL NAME (Last, First, Middle)	Date-of-Birth	Age	R/S	AIS #
Clayton, Sidney	8-23-76	26	B/M	224797

ORIGINAL - Blue Medical Jacket
YELLOW - Inmate
PINK - Warden

F-13 S. Clayton

B/224797

DOC N610
09/87

ALABAMA DEPARTMENT OF CORRECTIONS

RECEIVING SCREENING FORM

INMATES NAME: CLAYTON, SIDNEY DATE: 12-11-02 TIME: 11:25

DOB: 3-23-76 OFFICER: [signature] INSTITUTION: VCF

BOOKING OFFICERS VISUAL OPINION	Yes	No
1. Is the Inmate Conscious ?	Yes	✓
2. Does the inmate have any obvious pain or bleeding/other symptoms suggesting the need for emergency services ?	—	✓
3. Are there any visible signs of trauma or illness requiring immediate emergency or doctor's care ?	—	✓
4. Any obvious fever. swollen lymphnodes, jaundice, or other evidence of infection which might spread through the institution ?	—	✓
5. Is the skin in poor condition or show signs of vermin or rashes ?	—	✓
6. Does the inmate appear to be under the influence of Alcohol, or Drugs ?	—	✓
7. Are there any visible signs or Alcohl or Drug withdrawal ? (Extreme perspiration, shakes, nausea, pinpoint pupils etc)	—	✓
8. Is the inmate making any verbal threats to staff or other inmates ?	—	✓
9. Is the inmate carring any medication or report that he is on any medication which must be continuously administered or available ?	—	✓
10. Does the inmate have any obvious physical handicaps ?	—	✓

IF THE ANSWER IS YES TO ANY QUESTIONS FROM 2 to 10 ABOVE - SPECIFY WHY IN SECTION BELOW

11. Are you presently taking medication for diabetes, heart disease, seizure, athritis, asthma, ulcers, high blood pressure or psychiatric disorder?	—	✓
12. Are you on any special diet prescribed by a physician ? (if yes - what type ?)	—	✓
13. Do you have a history of veneral disease or abnormal discharge ?	—	✓
14. Have you recently been hospitalized or recently seen a medical or psychiatric doctor for any illness ?	—	✓
15. Have you ever attempted suicide ? (If yes - When ?_____ How ?_____.	—	✓
16. Do you want to do any harm to yourself now ?	—	✓

	Yes	No	No Responce
17. Do you want to talk to a mental health counselor ?		✓	
18. Are you allergic to any medication ?		✓	
19. Have you recently fainted or had a head injury ?		✓	
20. Do you have epilepsy ?		✓	
21. Do you have a history of tuberculosis ?		✓	
22. Do you have diabetes ?		✓	
23. Do you have hepatitis ?		✓	
24. Do you have a painful dental problem ?		✓	
25. Do you have any medical problem we should know about ?		✓	
26. Do you have a past alcohol or drug history ?	✓		

What type: Beer How much used: Case a day
For how long: 10 yrs
Last time you used any: NOV 2006

COMMENTS: (Unusual behavior etc.)

FOR THE OFFICER:

27. Was the new inmate briefed on sick/dental call procedures? YES

28. This inmate was:
a. Release for normal processing ✓
b. Referred to appropriate health care unit
c. Immediately sent to health care unit

Officer's Signature

NOTE: This form is completed on inter & intra system transfers at receiving and will be filed in the inmates medical jacket to comply with ACA Standards 2-4289, 2-4290 and AMA Standard 140.

Inmate's Signature

HEALTH CARE UNIT
PATIENT INFORMATION SLIP

KCF

INSTITUTION

Clayton, Sidney — NAME

224797 — NUMBER

B/M — R/S

Lay-in for _____ days from _____ to

(date)

_____ due to _____

(date)

Instructions: Shave profile

Clippers only X

90 days

Failure to follow the directions above may result in a disciplinary.

12/6/02

Date Issued

Signature

DEPARTMENT OF CORRECTIONS

PATIENT CONSENT TO TREATMENT FORM

Clayton Sidney (Name of Patient) 26 (Age) 12/3/02 (Admission date/time)

Name and Address of Spouse or Parent

1. I hereby authorize the Department of Corrections, its contracted employees, agents, physicians, dentists, psychiatrists and/or such assistants as may be selected by him/her to treat the condition(s) which appear indicated by the diagnostic studies already performed.

2. Should surgical or diagnostic procedure(s) become necessary, I will be informed of them with regard to alteration modes of treatment, the risks involved, and the nature of the procedure(s) to be done.

3. This in no way constitutes a warranty or guarantee that my present condition will be cured; the Department of Correction, its contracted staff and employees, will provide with the best possible care available, but no assurance of cure is to be assumed.

4. I sign this willingly and voluntarily in full understanding of the above, and in so doing I release the Department of Correction, its directors and officers, its contracted staff employees, agents, and physicians from any and all liability which may arise from this action, whether or not foreseen at present.

W. M. (Witness)

Witness

Sidney Clayton (Patient Signature)

12/3/02 (Date)

F-83

NAPHCARE

ACCESS TO HEALTH CARE SERVICES @ KILBY

All inmates have access to healthcare 24 hrs. a day, 7 days a week. Treatment for routine health services complaints is processed through nurse sick call. You must complete a sick call screening form for requested health care evaluation.

Various doctor's clinics are held in the health unit Monday through Friday. If you are scheduled to be seen in a clinic you will be advised by facility daily newsletters routinely post notices of who is to report when and where for health care services. If you complete a sick-call form, please report to sick call the next business day, no later then 5:30am. Routine sick call will not be posted in the newsletter, but D.O.C. has a log of who has signed up for sick call.

If you request health services and do not show for evaluation you must sign a refusal of treatment form. If a health services appointment/clinic or treatment has been set for you and you do not show you will also have to sign a refusal of treatment for. This is to let us know you have decided you are okay and no longer need to see us.

Nurses are in house twenty-four hours a day seven days a week for rontine health services and programs. Nurses are also available for emergency care. Doctor's are on call twenty-four hours a day seven days's a week.

In-house medical staff reviews medical services requested over the weekend and on holidays. If your request is noted to be of a nature that will not wait until the next regularly scheduled evaluation (triage) time, you will be called to the health unit for further follow-up during this time period other wise your request will be held until the next regularly scheduled evaluation process.

Medical emergencies such as those involving intense pain, potential life threatening situations or when delaying treatment might cause permanent damage are dealt with at any time. Advise the nearest correctional officer of an emergency so prompt access to health services is provided.

Medications ordered for you by health services are to be picked up at the scheduled pill call/s established as the Doctor has ordered for you. If you fail to pick-up medications as expected you will be called for counseling. If you continue to fail to pick-up your medications you will be required to sign a refusal of treatment form.

Remember that health services are a joint effort between the patient and the health car provider. We expect you to help us help you.

Fee for services. You truly understand that no one would be denied access to health services because they are unable to pay the $3.00 co-pay fee. You will be seen and services will be provided that are appropriate and deemed necessary. Health services staff

does not collect co-pay fees for health services nor do monies collected go to the medical provider. A nurse visit or doctor visit charge of $3.00 is the co-pay fee. If you do not have money in your PMOD account and you are accessed a charge you will have a negative balance in your until this is cleared. A negative balance will follow you from institution to institution upon transfer. When you seek health services you will be asked to sign the co-pay signature sheet. If it is deemed that you indeed do not owe for services your account will not be charged and if a false charge is made you will be refunded. Again we do have money and are eligible to be charged the co-pay fee this will occur. If the health unit initiates the request for you to be seen there is no charge.

Educational in-services are routinely scheduled. Please attend and participate. Notice of in-services topics, dates and times will be published and posted in advance.

Complaints against health care are attempted to be resolved as soon as possible and as reasonably as possible. You may obtain a complaint form from the same place you obtain sick call request slips and you may return these where you return your sick call request slips. If your complaint is not resolved when health services person speaks with you, you may file a grievance. This form will be given to you by the health person that has attempted to resolve the complaint. A complaint form must be initiated before a grievance form can be completed.

Let your family and loved one's know health services will not disclose your medical care through conversations with them. If we are contacted you should know that we will review your health records but will have to let them know what you feel they should know about you. Understand, we will assure your family and loved one's you have health services available. We will also tell them that they must go through you or the Department of Corrections fro release if information and that you must go through the appropriate procedures and access health services and also follow medical service recommendations. Be compliant with the health services ordered for you by your health providers.

If you have had health services outside the prison setting and we do not have these records you will need to sign release of records forms so we can obtain copies for placement in your institutional health record.

A physical is begun on you upon your arrival into the prison system. You will be notified yearly thereafter when you next physical is scheduled.

Mental health services dental services; medical services, chronic care clinics and many other health services are available. We wish you a healthy stay. If you need medical services we want you to understand how these services are obtained.

Certain over the counter medications are available to you through canteen purchase Medical service is not involved in canteen operations

We follow doctor's orders when dispensing medication-dose time. If over the counter medication is given by health services it is through the order of a doctor.

Population pill call at this institution are scheduled as listed below. If you have medication ordered report to the pill call your medication is to be dispensed at.
3:00AM
9:00AM
3:00PM
6:00PM

segregation lock-up pill call times are as listed below. Your medication will be issued to you on medication rounds.

3:00 AM
8:00 AM
2:30PM

If you have a question request an answer.

Sidney Clayton
INMATE SIGNATURE/ DATE

WITNESS SIGNATURE/DATE

RECEIVING SCREENING FORM

INMATE'S NAME: Clayton, Sidney **DATE:** 12/02/02 **TIME:** 8:25Am

DOB: 3-23-76 **OFFICER:** Freddie McCampbell **INSTITUTION:** KILBY

RECEIVING OFFICER'S VISUAL OPINION

	YES	NO
Is the inmate conscious?	✓	
Does the inmate have any obvious pain or bleeding or other symptoms suggesting the need for doctor's care?		✓
Are there any visible signs of trauma or illness requiring immediate emergency or doctor's care?		✓
Any obvious fever, jaundice, or other evidence of infection which might spread through the institution?		✓
Is the skin in poor condition or show signs of vermin or rashes?		✓
Does the inmate appear to be under the influence of alcohol, or drugs?		✓
Are there any signs of alcohol or drug withdrawal? (Extreme perspiration, shakes, nausea, pinpoint pupils, etc.)		✓
Is the inmate making any verbal threats to staff or other inmates?		✓
Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?		✓
Does the inmate have any obvious physical handicaps?		✓

FOR THE OFFICER

Was the new inmate oriented on sick/dental call procedures?

This inmate was ✓ a. Released for normal processing

____ b. Referred to health care unit

____ c. Immediately sent to the health care unit.

F.M. Campbell

Officer's Signature

This form will be completed at receiving and will be filed in the inmate's medical jacket to comply with NCCH Standards.

HUNGER STRIKE INITIAL EVALUATION

INMATE NAME: Clayton, Sidney AIS #: 224797

DATE: 12/5/05 FACILITY: Ventress

INITIAL EVALUATION

SUBJECTIVE:

INMATE REASONS FOR HUNGER STRIKE:
"Scared DOC will do something to him because he witnessed an altercation"

LAST DATE FOOD WAS EATEN: 12/4/05

CURRENT MEDICAL PROBLEMS:
1. dizziness
2. Malaria
3.
4.

CURRENT MEDICATIONS & TREATMENT PLANS:
1. Humbid 600mg B.I.D
2. Phenergan 50mg STAT
3.
4.
5.
6.

OBJECTIVE:

WEIGHT: 186 B/P: 122/80 T: 97.8 P: 22 R: 20

U/A (KETONES): _____

CURRENT NUTRITIONAL STATUS:
APPEARANCE: Good
SKIN TURGOR: Good
MUCOUS MEMBRANES: membranes good (mucous)

ADDITIONAL COMMENTS:

HUNGER STRIKE FLOW SHEET

INMATE NAME: Clayton, Sidney AIS #: 224797

DATE: 12/5/05 FACILITY: Ventress

DAY Shift	DATE	WEIGHT	B/P	T	P	R	FOOD EATEN 1st Shift	2nd Shift	3rd
1st	12/5/05	186	122/80	97.8	22	20	Y (N)	Y N	Y N
2nd	12/6/05		120/82	99.2	74	20	Y N	(Y) N	Y N
	/ /		/, , , ,				Y N	Y N	Y N
	/ /		/, , , ,				Y N	Y N	Y N
	/ /		/, , , ,				Y N	Y N	Y N
	/ /		/, , , ,				Y N	Y N	Y N
	/ /		/, , , ,				Y N	Y N	Y N
	/ /		/, , , ,				Y N	Y N	Y N
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	/ /		/, , , ,				Y N	Y N	Y N
	/ /		/, , , ,				Y N	Y N	Y N
	/ /		/, , , ,				Y N	Y N	Y N
	/ /		/, , , ,				Y N	Y N	Y N
	/ /		/, , , ,				Y N	Y N	Y N
	/ /		/, , , ,				Y N	Y N	Y N

PHS

Nursing Evaluation Tool: General Sick Ca

Facility: VENTRESS

Patient Name: Clayton Sidney (Last / First / MI)

Inmate Number: 240797

Date of Birth: 03 / 23 / 1979 (MM / DD / YYYY)

Date of Report: 12 / 04 / 2005 (MM / DD / YYYY)

Time Seen: 735 (AM / PM Circle One)

Subjective: Chief Complaint(s): C/o abd pain, ? N/V, none seen on assessment

Onset: 12-3-05 about 0001, 1238 am

Brief History: (Continue on back if necessary)

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 98.8 P: 70 RR: 20 B/P: 120 / 70 o2 sat 99% wt 190

Examination Findings: (Continue on back if necessary) Abd soft non distend, C/o pain to touch abd, ~~doesn't~~ responds slowly to verbal questions, states last BM 12-3-05 AOX3; 745- NO N/V noted @ this time ~~ambulates~~ ambulates c steady gait c assistance of 1 inmate

☐ Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s): Alt Comfrt

☐ Referral NOT REQUIRED

☑ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☒ Other: Dr Ryapati notified via phone c order to leave inmate in Seg placement noted N/V ~~if~~ if states change notified Dr Ryapati, F/U in am

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☐ Instructions to return if condition worsens.

☑ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: (Describe) Instructed inmate if ~~pt~~ permitted to notify Nursey and DOC don't flush toilet before staff sees results

OTC Medications given ☐ NO ☐ YES (If Yes List):

Referral: ☐ NO ☑ YES (If Yes, Whom/Where): Dr Ryapati Date for referral: 12 / 05 / 05 (MM / DD / YY)

Referral Type: ☐ Routine ☐ Urgent ☑ Emergent (if emergent who was contacted?): Dr Ryapati Time 740 am 12-5-05

x A Marsh LPN

Nurses Signature Name: A Marsh LPN

Printed

PHS PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

TRANSFER & RECEIVING SCREENING FORM

RECEIVED: Inmate/Health Record
Institution: RCHF
Date: 8/28/06 Time: 315 AM/PM
RECEIVED FROM:
Institution/Work Release Center/Free-World Hospital
Bullock
RECEIVING MEDICAL STATUS
☒ Population
☐ Infirmary
☐ Isolation

RELEASED: Inmate/Health Record
Institution: Bullock
Date: 8/28/06 Time: 500 AM/PM
RELEASE FROM:
☐ Infirmary ☐ Segregation
☒ Population ☐ Mental Health
☐ Other
RELEASE TO:
☒ DOC ☐ Infirmary ☐ Mental Health
☐ Institution/Work Release Center/Free-World Hospital

ALLERGIES:
NKA

PHYSICAL EXAMINATION
Date of last exam: 3-24-05
Chest X-Ray Date: Result:
PPD Reading 3-26-05 0mm
Classification:
Limitations:

LAB RESULTS - - LAST REPORT

	Date	Normal	Abnormal
CBC		☐	☐
Urinalysis		☐	☐
		☐	☐

	YES	NO
Wears Glasses/Contacts	☑	☐
Dental Prosthesis	☐	☑
Hearing Aide	☐	☑
Other Prosthesis	☐	☑

Recieving Nurse

CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS
Dizziness, Allergies Sinuites

CURRENT MEDICATION - - DOSAGE AND FREQUENCY

MEDICATIONS	☐ Sent w / inmate	☐ Not sent w / inmate
X-RAY FILM	☐ Sent w / inmate	☐ Not sent w / inmate
HEALTH RECORD	☒ Sent w / inmate	☐ Not sent w / inmate

Released to: DOC
Date: Time: AM/PM

MEDICATIONS	☐ Received	☐ Not Received
X-RAY FILM	☐ Received	☐ Not Received
HEALTH RECORD	☑ Received	☐ Not Received
CHART REVIEWED	☑ YES	☐ NO

Received by:
Signature of Receiving Nurse
Date: 8/28/06 Time: 315 AM/PM

SCHEDULE FOR CHRONIC CARE CLINIC
DATE: LAST CLINIC:

FOLLOW-UP CARE NEEDED
☐ Medical ☐ Dental ☐ Mental Health

Date	Time	With Whom - - Location (Sending Nurse)	Date/Appt. Made w/Whom (Rec. Nurse)

NURSING ASSESSMENT (SENDING NURSE) (Noted from health record documentation)

		Yes	No
HISTORY	Drug Use		
	Mental Illness		
	Suicide Attempt		
	Chronic Care		
STATUS	Special Diet		
	Appearance		

OTHER PERTINENT NURSING ASSESSMENT

L. Anderson LPN
Signature of Nurse Completing Assessment (Sending Nurse)
8/28/06
Date

NURSING ASSESSMENT (RECEIVING NURSE) (Noted from inmate assessment)

		Yes	No
SKIN	Open Sores		✓
	Lice		✓
	Edema		✓
	Warm & Dry	✓	
	Cool & Moist		✓
CONDITION	Alert	✓	
	Oriented	✓	
	Uncooperative		✓
	Depressed		✓

INTAKE

Sick Call Procedures Explained	✓
Height	6'03
Weight	220
Blood Pressure	
Temperature	
Pulse Resp	
Other	

8/28/06
Signature of Intake Screening Nurse (Receiving Nurse)
8/28/06
Date

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	Race/Sex	FAC
Clayton Sidney	224797	3/23/76	B/m	Bullock

70009
(White - Medical Jacket Yellow - Transfer Copy)

PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME:

D.O.B. / /

ALLERGIES:

Use Last Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

D.O.B. / /

ALLERGIES:

Use Fourth Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

D.O.B. / /

ALLERGIES:

Use Third Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: CLAYTON, SIDNEY 224797

D.O.B. / /

ALLERGIES:

Use Second Date 7,26 06

DIAGNOSIS (If Chg'd)

ORDER GLASSES (INMATE'S EXPENSE)
- LOST 3/06 GLASSES

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Clayton, Sidney
AIS 224797

D.O.B. / /

ALLERGIES:

Use First Date 5 14 106

DIAGNOSIS

Advil 800mg PO tid x 10 days
PO Dr Siddiq

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY

60110 (4/03)

PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Clayton, Sidney 224792

D.O.B. / /

ALLERGIES:

Use Last Date 4/9/06

DIAGNOSIS (If Chg'd) Kilby Eye Clinic

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

D.O.B. / /

ALLERGIES:

Use Fourth Date / /

DIAGNOSIS (If Chg'd) Advil 800 po tid x10d

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

D.O.B. / /

ALLERGIES:

Use Third Date / /

DIAGNOSIS (If Chg'd) Eye doctor list

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

D.O.B. / /

ALLERGIES:

Use Second Date / /

DIAGNOSIS (If Chg'd) Keyback Until seen by Eye doctor

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Clayton, Sidney 224792

D.O.B. / /

ALLERGIES:

Use First Date 4/11/06

DIAGNOSIS Proventil 4mg-Po bid x 10 days
CTM 8mg-PO qd x 10 days
Cough Tabs-PO bid x 10 days
Proventil Inhaler-puffs PRN
P.O Dr Seeding

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME:

D.O.B. / /

ALLERGIES:

Use Last Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

D.O.B. / /

ALLERGIES:

Use Fourth Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

D.O.B. / /

ALLERGIES:

Use Third Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Clayton Sidney 224797

D.O.B. / 4/27/06

ALLERGIES:

Use Second Date 4/22/06

DIAGNOSIS (If Chg'd)

Shoving profile x 120 days
T.O. Dr Siddiq / m Jackson

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Sidney Clayton 224797

D.O.B. 3/23/76

ALLERGIES:

Use First Date / /

DIAGNOSIS

Augmentin 750 tid x 10 days
Clay 8 mg po qd x 30 d

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY

60110 (4/03)

PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Clayton Sidney
224797
D.O.B. 3/23/76
ALLERGIES: NKA
Use Last Date 3/30/06

Noted
Mark
3-30-06
9:00

DIAGNOSIS (If Chg'd)
Prevent Tabs 4 mg p.o Bid x 2 Wks
Humibid 600 mg p.o Bid x 2 Wks
CTM 5 mg p.o QD x 2 Wks
RTC PRN

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Clayton Sidney
224797
D.O.B. 3/23/76
ALLERGIES: NKA
Use Fourth Date 3/24/06

Noted
Mark
3-24-06
8:45

DIAGNOSIS (If Chg'd)
Humibid 600 mg p.o Bid x 2 Weeks
Prevent Inhaler 2 puffs Q4H-PRN #1 x 6 mo
RTC PRN

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Clayton, Sidney
224797
D.O.B. 3/23/76
ALLERGIES: NKA
Use Third Date 3/17/06

Noted per
G Johnson
3-17-06
1515

DIAGNOSIS (If Chg'd) Admit ERE / Asthma
Jet Nebs daily x 7 day 5A
Humibid 600 mg p.o Bid x 7 day 3-3
Prevent Tabs - 4 mg p.o Bid x 2 Wks
Prednisone 20 mg p.o QD x 2 Wks
RTC PRN

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Clayton, Sidney
224797
D.O.B. 3/23/76
ALLERGIES: NKA
Use Second Date 3/15/06

noted by
3-15-06
morning
1330

DIAGNOSIS (If Chg'd)
Bengay Ointment topical QD Apply to lower BACK PRN x 1 month Keep
RTC PRN

☐ GENERIC SUBSTITUTION IS NOT PERMITTED Hard copy

NAME: Clayton, Sidney
224797
D.O.B. 3/23/76
ALLERGIES: NKA
Use First Date 2/19/06

DIAGNOSIS
HIV/RPR — yearly physical

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY

60110 (4/03)

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Clayton, Sidney #224797 noted [illegible] D.O.B. ~~12/18/05~~ 032376 010306 ALLERGIES: NKDA Use Last Date 1/3/05 1500 Am	DIAGNOSIS (If Chg'd) DC crutches Back Exercises daily x 90 day Moist heat to the affected area – as needed – 3mo ✓ Bp – weekly x 3 – F/U [illegible] for Bp – ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Clayton Sidney D.O.B. / / ALLERGIES: NKA Use Fourth Date 12/20/05	DIAGNOSIS (If Chg'd) ~~DC Motrin~~ ~~Back Exercises daily x 30 days~~ error ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Clayton Sidney 224797 D.O.B. ~~12/18/05~~ 032376 ALLERGIES: NKA Use Third Date 12/18/05 Noted [illegible] 12/18/05	DIAGNOSIS (If Chg'd) Motrin 600mg po TID x 7 days V/O Dr Rayapati / [illegible] ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Clayton Sidney 224797 D.O.B. 3/23/76 ALLERGIES: NKA Use Second Date 12/16/05 [illegible]	DIAGNOSIS (If Chg'd) [illegible] 600mg T b.i.d. x 4d [illegible] b.i.d. x 4d [illegible] T b.i.d. x 4d v/o Dr. Rayapati [illegible] RN ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Clayton, Sidney 224797 noted 12-8-05 1240p [illegible] D.O.B. 3/23/76 ALLERGIES: NKDA Date 12/8/05	DIAGNOSIS Shoulder Profile Clinic Shoulder X-ray v/o Dr. Rayapati [illegible] RN ☐ GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY

PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Clayton Sidney 120605 12:00pm

D.O.B. 3/23/76

ALLERGIES: NKA

Use Last Date 12/20/05

noted 12/20/05

DIAGNOSIS (If Chg'd)

(1) Back Exercises – daily x 30 days
(2) diet RTC PRN
(3) Moist heat to the affected area 20 mts – daily x 2 wks –
(4) MAT - Counseling for Psychotherapeutic

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Clayton Sidney 120605

D.O.B. 3/23/76 NKA

ALLERGIES:

Use Fourth Date 12/7/05

noted 12-7-05 9:30

DIAGNOSIS (If Chg'd)

dischs medical

R

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Clayton Sidney 120605

D.O.B. / /

ALLERGIES: NKA

Use Third Date 12/6/05

noted 12/6/05 11:30

DIAGNOSIS (If Chg'd)

XR – Thoracic Spine 2 views done
XR – LS Spine 2 views – done
percogesic 2 tab P.O Bid – PRN – x5 day
RTC 1 wk
Moist heat. Thoracic and Lumbar Spine 15 mts Bid x5 day

R

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Clayton, Sidney #224797

D.O.B. 3/23/76

ALLERGIES: NKDA

Use Second Date 12/05/05

noted GMassey 12/05/05

DIAGNOSIS (If Chg'd)

(1) Place in Seg cell lying flat on back
(2) Remove all Hazardous material
(3) will see in Am.

V/O Dr. Kayapati / GMassey ln

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Clayton, Sidney #224797

D.O.B. 3/23/76

ALLERGIES: NKDA

Use First Date 12/05/05

noted GMassey 12:05

DIAGNOSIS

(1) Place on strecther et transported to ER for examine
(2) Call report – examination

V/O Dr. Kayapati / GMassey ln

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Clayton, Sidney #224797 D.O.B. 3/23/76 ALLERGIES: NKA Use Last Date 12/05/05	DIAGNOSIS (If Chg'd) (1) Phenergan 50mg IM stat (2) Humibid [illegible] P.O Bid x 2 wks. (3) Regular diet noted 12-5-05 [illegible] 1145 ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Clayton, Sidney #224797 D.O.B. 3/23/76 ALLERGIES: NKA Use Fourth Date 10/24/05 noted 10/24/05 1240 [illegible]	DIAGNOSIS (If Chg'd) Saline Nasal Spray Bid x PRN 90day (KOP) [illegible] 8mg P.O [illegible] x 10 day [illegible] PRN ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Clayton, Sidney #224797 D.O.B. 3/23/76 ALLERGIES: NKDA Use Third Date 10/14/05 noted [illegible]	DIAGNOSIS (If Chg'd) Sudafed 30mg Po Bid x 1mo. o/o [illegible] Lloyd CRNP. [illegible] ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Clayton, Sidney #224797 D.O.B. 3/23/76 ALLERGIES: NKDA Use Second Date 9/14/05 noted [illegible] 9/14/05 [illegible]	DIAGNOSIS (If Chg'd) allergic Sinusitis Ctm T po BID X 1 month PRN after 1 week of cold protocol over ☐ GENERIC SUBSTITUTION IS NOT PERMITTED [illegible]
NAME: Clayton, Sidney #224797 D.O.B. 3/23/76 ALLERGIES: NKDA Use First Date 9/14/05 noted [illegible] 9/14/05 1435	DIAGNOSIS acute allergic Sinusitis Sudafed II po BID X 7 days 30mg Cough tabs T po BID X 10 days Ctm II po BID X 7 days Doxycycline 100 mg T po BID X 7 days ☐ GENERIC SUBSTITUTION IS NOT PERMITTED [illegible]

PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Clayton, Sidney 224797
D.O.B. 3 23 76
ALLERGIES: NKDA
Use Last Date 9 18 105

DIAGNOSIS (If Chg'd)
Keflex 500 mg PO b.i.d. x 4d
Motrin 600 mg PO b.i.d. x 4d
CTM 4 mg PO b.i.d. x 4d
V/O Dr. Rayapati / Smith LPN
☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Clayton, Sidney #224797
D.O.B. 3 23 76
ALLERGIES: NKDA
Use Fourth Date 3 15 105

DIAGNOSIS (If Chg'd)
TB skin test
-per APY protocol
V/O Dr. Rayapati / CHunter, LPN
☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Clayton, Sidney #224797
D.O.B. 3 23 76
ALLERGIES: NKA
Use Third Date 12 17 04

Noted Johnson RN 12.17.04 1425

DIAGNOSIS (If Chg'd)
SIP - one year
☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Clayton, Sidney #224797
D.O.B. 3 23 76
ALLERGIES: NKA
Use Second Date 6 18 04

noted 6-18-04 mount read 1:35

DIAGNOSIS (If Chg'd)
SIP 6mo
☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Clayton, Sidney
D.O.B. / /
ALLERGIES: NKA
Use First Date 12 16 03

DIAGNOSIS facial folliculitis
Shaving profile x 6 mon
noted 12-16-03
☐ GENERIC SUBSTITUTION IS NOT PERMITTED Ashley Crews

MEDICAL RECORDS COPY

60110 (4/03)

Name (Last, First, Middle Initial): Clayton, Sidney	AIS # 224797
Date 6/18/03 Allergies NKDA	Facility VCF
SIG. Shaving profile x 6 mon	Discontinue / Continue / Increase / Decrease: Noted 6-18-03 RN [illegible]
Physician Signature: Cooley, CRNP	

NC002

Name (Last, First, Middle Initial): Clayton, Sidney	AIS # 224797
Date 5/12/03 Allergies NKDA	Facility VCF
SIG. EKG - Motrin 800mg po TID x 14 days ~~[illegible]~~	Discontinue / Continue / Increase / Decrease: Noted [illegible] 5-12-03 2320
Physician Signature: Cooley, CRNP	

NC002

Name (Last, First, Middle Initial): Clayton, Sidney	AIS # [illegible]
Date 12/17/02 Allergies NKDA	Facility VCF
SIG. (2) Shaving profile x 6 mos	Discontinue / Continue / Increase / Decrease: Noted [illegible] 12/17/02
Physician Signature: [illegible] 12/17/02 @ 1320	

NC002

Name (Last, First, Middle Initial): Clayton, Sidney	AIS # 224797
Date 12/17/02 Allergies NKDA	Facility VCF
SIG. (1) Benzoyl peroxide 5% lotion BID x 14 days (KOP) (2) Tetracycline 250mg po TID x 7 days	Discontinue / Continue / Increase / Decrease: Noted [illegible] 12/17/02
Physician Signature: [illegible] 12/17/02 @ 1320	

NC002